		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0023317

Facility Name: Eldercare of Alton

Address: 3525 Wickenhauser (Number) Alton (City) 62002 (Zip Code)

County: Madison

Telephone Number: 618-465-8887 **Fax #** 618-465-1811

IDPA ID Number: 37-1024089002

Date of Initial License for Current Owners: 4/1/1977

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: David Read **Telephone Number:** 618-234-2273

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Steven C. Wolf
(Title) Executive Administrator

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	132	Skilled (SNF)	132	48,312	1
2		Skilled Pediatric (SNF/PED)			2
3	49	Intermediate (ICF)	49	17,934	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	181	TOTALS	181	66,246	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	36,028	3,785	1,564	41,377	8
9	SNF/PED					9
10	ICF	13,325	1,400		14,725	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	49,353	5,185	1,564	56,102	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.69%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/01/1977

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 40 and days of care provided 1,564

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	219,908	13,680	9,475	243,063		243,063		243,063			1
2	Food Purchase		325,442		325,442		325,442		325,442			2
3	Housekeeping	217,081	21,216		238,297		238,297		238,297			3
4	Laundry	99,727	25,918		125,645		125,645		125,645			4
5	Heat and Other Utilities			121,341	121,341		121,341	1,533	122,874			5
6	Maintenance	68,454	22,811	22,358	113,623		113,623	3,350	116,973			6
7	Other (specify):*											7
8	**TOTAL General Services**	605,170	409,067	153,174	1,167,411		1,167,411	4,883	1,172,294			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	1,966,361	85,588	134,042	2,185,991	11,955	2,197,946		2,197,946			10
10a	Therapy			100,986	100,986		100,986		100,986			10a
11	Activities	53,095	8,706		61,801	3,478	65,279		65,279			11
12	Social Services	69,319	5	6,957	76,281	(3,478)	72,803		72,803			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,088,775	94,299	265,985	2,449,059	11,955	2,461,014		2,461,014			16
	C. General Administration											
17	Administrative	159,731		74,134	233,865		233,865	(74,134)	159,731			17
18	Directors Fees											18
19	Professional Services			7,453	7,453		7,453	2,237	9,690			19
20	Dues, Fees, Subscriptions & Promotions			50,563	50,563		50,563	(26,941)	23,622			20
21	Clerical & General Office Expenses	352,281	10,339	94,401	457,021	(4,275)	452,746	8,762	461,508			21
22	Employee Benefits & Payroll Taxes			418,841	418,841		418,841	32,600	451,441			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,420	5,420		5,420	650	6,070			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			141,736	141,736		141,736	1,023	142,759			26
27	Other (specify):* sales tax			2,662	2,662		2,662	(2,662)				27
28	**TOTAL General Administration**	512,012	10,339	795,210	1,317,561	(4,275)	1,313,286	(58,465)	1,254,821			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,205,957	513,705	1,214,369	4,934,031	7,680	4,941,711	(53,582)	4,888,129			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Eldercare of Alton #0023317 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			119,140	119,140		119,140	5,557	124,697			30
31	Amortization of Pre-Op. & Org.											31
32	Interest					4,275	4,275		4,275			32
33	Real Estate Taxes			95,136	95,136		95,136		95,136			33
34	Rent-Facility & Grounds			319,720	319,720		319,720	15,920	335,640			34
35	Rent-Equipment & Vehicles			353	353		353		353			35
36	Other (specify):*											36
37	**TOTAL Ownership**			534,349	534,349	4,275	538,624	21,477	560,101			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		57,479		57,479	(11,955)	45,524		45,524			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		9,998		9,998		9,998		9,998			41
42	Provider Participation Fee			99,370	99,370		99,370		99,370			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		67,477	99,370	166,847	(11,955)	154,892		154,892			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,205,957	581,182	1,848,088	5,635,227		5,635,227	(32,105)	5,603,122			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,662)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(16,250)	20		18
19	Entertainment				19
20	Contributions	(502)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(10,687)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(569)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (30,670)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,435)	schVII	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,435)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (32,105)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Eldercare of Alton

ID# 0023317

Report Period Beginning: 1/1/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Copy Income	$ (178)	21	1
2	Out of state travel	(391)	24	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(569)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,533	0	0	0	0	0	0	0	0	1,533	5
6	Maintenance	0	0	3,350	0	0	0	0	0	0	0	0	3,350	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	4,883	0	0	0	0	0	0	0	0	4,883	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(74,134)	0	0	0	0	0	0	0	0	(74,134)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	2,237	0	0	0	0	0	0	0	0	2,237	19
20	Fees, Subscriptions & Promotions	(27,439)	0	498	0	0	0	0	0	0	0	0	(26,941)	20
21	Clerical & General Office Expenses	(178)	0	8,940	0	0	0	0	0	0	0	0	8,762	21
22	Employee Benefits & Payroll Taxes	0	0	32,600	0	0	0	0	0	0	0	0	32,600	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(391)	0	1,041	0	0	0	0	0	0	0	0	650	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,023	0	0	0	0	0	0	0	0	1,023	26
27	Other (specify):*	(2,662)	0	0	0	0	0	0	0	0	0	0	(2,662)	27
28	**TOTAL General Administration**	(30,670)	0	(27,795)	0	0	0	0	0	0	0	0	(58,465)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(30,670)	0	(22,912)	0	0	0	0	0	0	0	0	(53,582)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Eldercare of Alton # 0023317 **Report Period Beginning:** 1/1/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	5,557	0	0	0	0	0	0	0	0	5,557	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	15,920	0	0	0	0	0	0	0	0	15,920	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	21,477	0	0	0	0	0	0	0	0	21,477	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(30,670)	0	(1,435)	0	0	0	0	0	0	0	0	(32,105)	45

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Steve Wolf	30	Calvin Johnson Care Center	Belleville	Eldercare Inc	Belleville	Nurs Home Mgt
	50	Columbia Convalescent Center	Columbia			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17-1	Home Office Adm Wages	$ 87,838	Eldercare Inc	0.00%	$ 87,838	$	1
2	V	21-1	Home Office Wages	159,088	Eldercare Inc	0.00%	159,088		2
3	V	21-3	Home Office Expenses	74,134	Eldercare Inc	0.00%	72,699	(1,435)	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 321,060			$ 319,625	$ * (1,435)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$	Eldercare Inc	0.00%	$ 1,533	$ 1,533	15
16	V	6	Maintenance		Eldercare Inc	0.00%	3,350	3,350	16
17	V	17	Officer Salary	87,838	Eldercare Inc	0.00%	87,838		17
18	V	19	Legal & Acctg		Eldercare Inc	0.00%	2,237	2,237	18
19	V	20	Dues & Licenses		Eldercare Inc	0.00%	498	498	19
20	V	21	Home Office Wages	159,088	Eldercare Inc	0.00%	159,088		20
21	V	21	Admin/office expenses		Eldercare Inc	0.00%	8,940	8,940	21
22	V	22	Payroll Taxes/benefits		Eldercare Inc	0.00%	32,600	32,600	22
23	V	24	Travel		Eldercare Inc	0.00%	1,041	1,041	23
24	V	26	Liability and Property insurance		Eldercare Inc	0.00%	1,023	1,023	24
25	V	30	Depreciation		Eldercare Inc	0.00%	5,557	5,557	25
26	V	34	Building Lease		Eldercare Inc	0.00%	15,920	15,920	26
27	V	35	Equipment Lease		Eldercare Inc	0.00%			27
28	V	17	Home Office Expenses	74,134	Eldercare Inc	0.00%		(74,134)	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 321,060			$ 319,625	$ * (1,435)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Steve Wolf	President	Executive Admin	30.00	A	20	0.33	Salary	$ 87,838	17-1	1
2											2
3											3
4											4
5											5
6											6
7											7
8			A Columbia Conv. Ctr		84,650						8
9			Calvin Johnson Care Ctr		82,091						9
10											10
11											11
12											12
13								TOTAL	$ 87,838		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Eldercare Inc
Street Address: 2810 Frank Scott Pkwy West Ste. 820
City / State / Zip Code: Belleville, IL 62223
Phone Number: (618-234-2273
Fax Number: (618-234-7777

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Patient Days	108,533	2	$ 2,966	$	56,102	$ 1,533	1
2	6	Maintenance	Patient Days	108,533	2	6,481		56,102	3,350	2
3	17	Home Office Adm Wages	Patient Days	108,533	2	169,929	169,929	56,102	87,838	3
4	19	Legal & Acctg	Patient Days	108,533	2	4,327		56,102	2,237	4
5	20	Dues & Licenses	Patient Days	108,533	2	964		56,102	498	5
6	21	Home Office Wages	Patient Days	108,533	2	307,766	307,766	56,102	159,088	6
7	21	Administrative expenses	Patient Days	108,533	2	17,296		56,102	8,941	7
8	22	Payroll Taxes/benefits	Patient Days	108,533	2	63,066		56,102	32,600	8
9	24	Travel	Patient Days	108,533	2	2,013		56,102	1,041	9
10	26	Liability and Property insur	Patient Days	108,533	2	1,979		56,102	1,023	10
11	30	Depreciation	Patient Days	108,533	2	10,750		56,102	5,557	11
12	34	Building Lease	Patient Days	108,533	2	30,799		56,102	15,920	12
13	35	Equipment Lease	Patient Days	108,533	2			56,102	0	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 618,336	$ 477,695		$ 319,626	25

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Universal Re		X	Finance Liability Ins Policy	$10,875.00	4/1/2004	119,625		3/31/2005	3.0000	4,275	6
7												7
8												8
9	TOTAL Facility Related				$10,875.00		$ 119,625	$			$ 4,275	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 119,625	$			$ 4,275	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Eldercare of Alton # 0023317 **Report Period Beginning:** 1/1/2004 **Ending:** 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	87,600	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	90,696	2
3. Under or (over) accrual (line 2 minus line 1).	$	3,096	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	92,040	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	95,136	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	80,281	8
	2000	82,765	9
	2001	85,655	10
	2002	86,689	11
	2003	90,696	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Eldercare of Alton COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0023317

CONTACT PERSON REGARDING THIS REPORT David Read

TELEPHONE 618-234-2273 FAX #: 618-234-7777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	23-1-08-17-10-105-027	Nursing Home & 4.42 Acres	$ 90,695.79	$ 90,695.79
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 90,695.79	$ 90,695.79

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 45,621 B. General Construction Type: Exterior Brick Frame Concrete/Steel Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Improvements			1982	2,080		10			2,080	9
10	Improvements			1983	2,575		10			2,575	10
11	Improvements			1985	3,728		7			3,729	11
12	Improvements			1985	10,578	529	20	529		10,314	12
13	Improvements			1986	5,506		10			5,506	13
14	Heat Range			1988	1,190		10			1,190	14
15	Door Alarm			1991	8,986	449	20	449		6,178	15
16	Nurse Station Remodeling			1991	60,801	4,053	15	4,053		54,721	16
17	Carpet			1991	1,482		5			1,482	17
18	Asphalet Sealer			1992	2,900	121	12	121		2,900	18
19	Remodeling			1992	77,249	5,150	15	5,150		64,374	19
20	Roof & Remodeling			1993	68,700	4,580	15	4,580		51,525	20
21	Remodel Hall & Offices			1994	20,445	1,363	15	1,363		14,917	21
22	Concrete			1994	1,677	112	15	112		1,146	22
23	Roof Repairs & Asphalt			1995	2,150	179	12	179		1,702	23
24	Waste Line Renovations			1996	15,112	756	20	756		6,423	24
25	New Therapy Room			1996	3,782	252	15	252		2,206	25
26	Awnings			1996	12,500	1,250	10	1,250		10,625	26
27	Sidewalks & Parking Lot Seal			1996	8,930	524	5-15y	524		5,525	27
28	Landscape			1996	7,436	744	10	744		6,135	28
29	Carpet			1997	1,950		5			1,950	29
30	Concrete Walls & Signs			1997	14,479	965	15	965		7,239	30
31	Hall Renovations			1998	3,516	351	10	351		2,285	31
32	Laundry Boiler			1998	1,241	83	15	83		580	32
33	Parking Lot			1998	14,062	1,172	12	1,172		7,617	33
34	Landscape			1998	1,383	138	10	138		968	34
35	Drywall,Wall Carpet,Stained Glass Door,Lighting Chapel			1999	20,560	2,056	10	2,056		10,794	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Tubesheets & Copper Tubes in Water Heater	1999	$ 6,904	$ 986	7	$ 986	$	$ 5,425	37
38	Drywall,Wall Carpet,Electric Work,and Flooring	2000	23,534	2,353	10	2,353		10,590	38
39	Duro-last Roofing System	2000	165,440	16,294	10	16,294		69,312	39
40	Roof-top HVAC Unit & 2 HVAC/Heat Unit-DR&Kitchen	2000	60,000	7,500	8	7,500		31,875	40
41	Foutain, Brick & Keystone install, Bush removal	2000	1,178	118	10	118		530	41
42	Asphalt Parking Lot	2001	7,745	645	12	645		2,259	42
43	Sidewalk entrance	2001	11,061	737	15	737		2,580	43
44	PA System	2001	573	115	5	115		401	44
45	Rooftop A/C	2001	4,133	517	8	517		1,808	45
46	Fireplace Dining Room/Awning	2001	3,917	392	10	392		1,371	46
47	New lighting-all wings/handrails	2001	49,081	3,272	15	3,272		11,452	47
48	New lighting	2002	5,788	386	15	386		1,158	48
49	Concrete pads	2002	1,882	94	20	94		282	49
50	Electrical rewiring kitchen	2003	7,770	388	20	388		777	50
51	Boiler room door, bathroom renovations	2003	4,564	456	10	456		684	51
52									52
53	Insurance proceeds on roofing system from 2000	2000	(2,500)						53
54	Generator, wiring, cable	2004	20,678	1,034	20	1,034		1,034	54
55	Handrails and installation	2004	13,980	932	15	932		932	55
56	Smoke detectors, emergency lighting, fire doors	2004	28,610	1,430	10	1,430		1,430	56
57	Carpeting, HVAC upgrades	2004	7,459	746	5	746		746	57
58									58
59	retirements 2004	1983	(750)					(750)	59
60	retirements 2004	1997	(1,950)					(1,950)	60
61									61
62									62
63	Home Office allocation			5,557		5,557			63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 794,095	$ 68,779		$ 68,779	$	$ 428,632	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 617,537	$ 54,785	$ 54,785	$	5-20 yr	$ 348,266	71
72	Current Year Purchases	16,579	1,133	1,133			1,132	72
73	Fully Depreciated Assets	107,825					107,825	73
74	retirements	(11,217)					(11,217)	74
75	TOTALS	$ 730,724	$ 55,918	$ 55,918	$		$ 446,006	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	1985 Van	1985	$ 10,041	$	$	$	5	$ 10,041	76
77	Patient Transportation	1991 Bus	1991	39,855				4	39,855	77
78										78
79										79
80	TOTALS			$ 49,896	$	$	$		$ 49,896	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,574,715	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 124,697	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 124,697	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 924,534	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Vending Machine	$ 4,584	$	$ 4,584	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 4,584	$	$ 4,584	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: National Nursing Homes Inc.
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1971	181	4/1/1977	$ 319,720	20	20	3
4	Additions							4
5								5
6	Home Office			12/01/03	15,920	5	5	6
7	TOTAL		181		$ 335,640 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease ____.

9. Option to Buy: [ ] YES [ ] NO Terms: ____ *

10. Effective dates of current rental agreement:
    Beginning 08/01/2002
    Ending 07/31/2007

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$ Base + profit share
13.	/2006	$ Base + profit share
14.	/2007	$ Base + profit share

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 353 Description: Office Equip
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A col 3	hrs	$	345	$	22,825	$	345	$ 22,825	1
2	Licensed Speech and Language Development Therapist	10A col 3	hrs		95		7,960		95	7,960	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	10A col 3	hrs		579		37,062		579	37,062	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39-2	# of prescrpts					57,579		57,579	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			$	1,019	$	67,847	$ 57,579	1,019	$ 125,426	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 121,699	$	1
2	Cash-Patient Deposits	27,327		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,721,463		3
4	Supply Inventory (priced at cost)	32,576		4
5	Short-Term Investments			5
6	Prepaid Insurance	35,153		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	278,112		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,216,330	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	843		11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	794,095		15
16	Equipment, at Historical Cost	780,619		16
17	Accumulated Depreciation (book methods)	(924,534)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 651,023	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,867,353	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 331,939	$	26
27	Officer's Accounts Payable	27,327		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	45,037		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,104		31
32	Accrued Real Estate Taxes(Sch.IX-B)	92,040		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 502,447	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 502,447	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,364,906	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,867,353	$	48

***(See instructions.)**

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,717,259	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,717,259	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(352,353)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (352,353)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,364,906	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,793,473	1
2	Discounts and Allowances for all Levels	(111,954)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,681,519	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	150,341	6
7	Oxygen	9,464	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 159,805	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	18,954	12
13	Barber and Beauty Care	2,975	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	76,924	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,624	19
20	Radiology and X-Ray	945	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 112,422	23
	D. Non-Operating Revenue		
24	Contributions	2,608	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,608	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Medical Supplies	324,412	28
28a	Misc Income	2,109	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 326,521	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,282,875	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,167,411	31
32	Health Care	2,449,059	32
33	General Administration	1,317,561	33
	B. Capital Expense		
34	Ownership	534,349	34
	C. Ancillary Expense		
35	Special Cost Centers	67,477	35
36	Provider Participation Fee	99,370	36
	D. Other Expenses (specify):		
37	Rounding	1	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,635,228	40
41	**Income before Income Taxes (line 30 minus line 40)****	(352,353)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (352,353)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** no **If not, please attach a reconciliation.**

consolidated return

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,320	1,320	$ 30,572	$ 23.16	1
2	Assistant Director of Nursing	480	480	11,047	23.01	2
3	Registered Nurses	7,024	7,334	168,159	22.93	3
4	Licensed Practical Nurses	26,609	28,513	527,499	18.50	4
5	Nurse Aides & Orderlies	88,928	95,031	1,040,587	10.95	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,907	8,537	90,153	10.56	8
9	Activity Director					9
10	Activity Assistants	5,949	6,328	53,095	8.39	10
11	Social Service Workers	5,987	6,371	69,319	10.88	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	25,248	12.14	13
14	Head Cook					14
15	Cook Helpers/Assistants	24,799	26,341	194,660	7.39	15
16	Dishwashers					16
17	Maintenance Workers	6,426	6,760	68,454	10.13	17
18	Housekeepers	29,352	31,100	217,081	6.98	18
19	Laundry	13,115	14,006	99,727	7.12	19
20	Administrator	3,040	3,120	159,731	51.20	20
21	Assistant Administrator					21
22	Other Administrative	6,879	7,199	159,088	22.10	22
23	Office Manager					23
24	Clerical	15,377	16,032	193,193	12.05	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	4,396	4,719	98,344	20.84	33
34	TOTAL (lines 1 - 33)	249,668	265,271	$ 3,205,957 *	$ 12.09	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	316	$ 8,567	1-3	35
36	Medical Director	varies	24,000	9-3	36
37	Medical Records Consultant	96	3,675	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	24	840		39
40	Physical Therapy Consultant	513	26,623	10A-3	40
41	Occupational Therapy Consultant	90	6,045	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	7	471	10A-3	43
44	Activity Consultant	99	3,478	11-3	44
45	Social Service Consultant	99	3,479	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,244	$ 77,178		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	532	$ 21,292	10-3	50
51	Licensed Practical Nurses	3,023	94,318	10-3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	3,555	$ 115,610		53

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Deborah Cutright	Administrator	0	$ 71,893
Steven Wolf	Exec Admin/Owner	30	87,838
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 159,731

B. Administrative - Other

Description	Amount
Eldercare Inc	$ 74,134
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 74,134

C. Professional Services

Vendor/Payee	Type	Amount
Burroughs Hepler Broom	Legal	$ 1,179
Van Ostrand & Kelley	Legal	5,852
Greensfelder Hemke Gale	Legal	261
Wesell & Pautsch	Legal	161
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 7,453

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 66,187
Unemployment Compensation Insurance	49,925
FICA Taxes	220,939
Employee Health Insurance	61,940
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other employee benefits	19,850
Home Office allocation	32,600
TOTAL (agree to Schedule V, line 22, col.8)	$ 451,441

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,810
Advertising: Employee Recruitment	17,545
Health Care Worker Background Check	856
(Indicate # of checks performed 71)	
City of Alton	120
Prof Org Fees	590
Secretary of State	78
Court fees	97
Misc Subscriptions	1,028
Home Office	498
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,622

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	5,029
Home Office allocation	1,041
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,070

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10						N/A							
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Eldercare of Alton **#** 0023317 **Report Period Beginning:** 1/1/2004 **Ending:** 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **no** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-15 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **364** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **99,370**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.